Indiana State Department of Health

Commodity Supplemental Food Program (CSFP)
Participant Application

Form CSFP 0003
April 2017

Local Agency _____ **Distribution Site** _____

Household Information (PLEASE PRINT) *To be completed by Applicant, Household Member, Authorized Representative or Agency that is determining eligibility.*

Name of Applicant (Last, First, Middle Initial	Site Name	Date of Birth / /
Address (Street, City, State, ZIP Code)	Area Code and Telephone No. - -	Gender (Circle One) Male Female

Have you ever received food from the Commodity Supplemental Food Program? □ Yes □ No

If yes, where? _____

Date applicant last received food from the CSFP:

Total Number of Household Members	Total Gross Income (before deductions) of all Household Members **$** Weekly Monthly Yearly	**Note:** SNAP benefits do not count as income.

CSFP Income Guidelines (130% of poverty)

I hereby certify that my household income is at or below the following guidelines: ***Yes [ ]*** ***No [ ]***

Household Size	Annual	Monthly	Household Size	Annual	Monthly
1	$ 15,678	$ 1,307	5	$ 37,414	$ 3,118
2	$ 21,112	$ 1,760	6	$ 42,848	$ 3,571
3	$ 26,546	$ 2,213	7	$ 48,282	$ 4,024
4	$ 31,980	$ 2,665	8	$ 53,176	$ 4,477
			For each additional household member, add	$ 5,434	$ 453

To be completed by program staff – Initial Application

Eligibility			**Category**	**Determination**	
Income	□ Yes	□ No	□ Elderly	□ Eligible	Date Determination Notice Sent:
Categorical	□ Yes	□ No	□ Not categorically eligible	□ Not Eligible	Determination Date:
Residence	□ Yes	□ No		□ Eligible–On Waiting List	Date of Initial Visit:
					Certification Period _____ - _____

Signature-Individual Making Determination	Title-Individual Making Determination

Recertification – To be completed by program staff □ 6-month extension, there were no changes

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					Certification Period _____ - _____

Signature-Individual Making Determination	Title-Individual Making Determination

Participant Acknowledgement

If placed on the program, I will pick up food as directed. Failure to pick up food as directed may result in being dropped from the program.

I understand that if I choose to send an alternate (proxy) to pick up my food, I must have a completed Proxy Form on file designating that person.

I understand that the food provided by this program is intended for the participant for whom it is prescribed.

Fair Hearing

I may appeal any adverse decision made regarding my eligibility for the Program. I or my caregiver may request a fair hearing by making a verbal or written request to a State or Local Agency official within 60 days of the notification date of an adverse action.

MUST BE COMPLETED. If applicant refuses, fill in this section based on intake person's visual determination.

Race: Black or African American □ Black or African American and White □ White □ Asian and White □ American Indian or Alaska Native □ American Indian or Alaska Native and Black or African American □ Native Hawaiian or Other Pacific Islander □ American Indian or Alaska Native and White □ Asian □

Ethnicity: Hispanic or Latino □ Not Hispanic or Latino □

Certification (MUST BE READ TO APPLICANT BEFORE SIGNING): This application is being completed in connection with the receipt of Federal assistance. Program officials may verify information on this form. I am aware that deliberate misrepresentation may subject me to prosecution under applicable State and Federal statutes. I am also aware that I may not receive CSFP benefits at more than one CSFP site at the same time. Furthermore, I am aware that the information provided may be shared with other organizations to detect and prevent dual participation. I have been advised of my rights and obligations under the program, including the right to appeal any decision made by the local agency regarding my denial or termination from the Program. I understand that the local agency will make nutrition education available to me and I am encouraged to participate. I certify that the information I have provided for my eligibility determination is correct to the best of my knowledge.

I authorized the release of information provided on this application form to other organizations administering assistance programs for use in determining my eligibility for participation in other public assistance programs and for program outreach purposes. (Please indicate decision by placing a checkmark in the appropriate box.)

YES [ ] NO [ ]

Signature – Applicant	Date	Name of Proxy – Optional (print or type)

STAFF CERTIFICATION: I certify I have read this page to the applicant and all items are completed.

Staff Printed Name	Date	Staff Signature

Nondiscrimination: This institution is an equal opportunity provider.